Section 1915(b) Waiver Proposal for Idaho's PCCM Program

Submitted by Idaho Dept. of Health and Welfare
June 23, 2004

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Proposal for Idaho's Section 1915(b) Waiver PCCM Program

The **State** of __Idaho___ requests a waiver/amendment under the authority of section 1915(b) of the Act. The Medicaid agency will directly operate the waiver.

The **name of the waiver program** is Healthy Connections__.

Type of request. This is an:
_X renewal request
_X This is the first time the State is using this waiver format to renew an existing waiver.

Effective Dates: This waiver/renewal/amendment is requested for a period of 2 years; effective _10-01-04__and ending _9-30-06_.

State Contact: The State contact person for this waiver is _Pam Mason__ and can be reached by telephone at (208) 364-1863_, or fax at (208) 334-2465_, or e-mail at _masonp@idhw.state.id.us.

Section A: Program Description

Part I: Program Overview

Tribal consultation

The Division of Medicaid meets with representatives from the Idaho Tribes quarterly regarding Medicaid issues. A letter was sent to the Tribes on May 20, 2004 notifying them of our intent to renew our HC waiver. In addition, the waiver renewal was discussed at the June 11, 2004 Medicaid/Tribal meeting. There were no comments or recommendations regarding the waiver renewal from the Tribes. (See Attached Letter and meeting agenda)

Program History

Idaho implemented its PCCM waiver program in 1993 and it has remained virtually unchanged in program design since its beginning. The program strives to remain as simple as possible and has the following goals:

- Ensure access to health care
- Provide health education
- Promote continuity of care
- Strengthen the physician/patient relationship
- Achieve cost efficiencies

During the previous waiver period, Idaho has significantly increased program participation throughout the state. As of June 2004, 35 of 44 of Idaho's counties require (mandatory) enrollment in Healthy Connections for all non-exempt populations. Enrollment has increased from 39.5% (June 2002) at the time of our last waiver renewal application to 79.5% in June of 2004. We will continue to bring up the remaining 9 counties as feasible.

During the remainder of the current waiver period and continuing in the renewal years, we will be continuing to evaluate the quality, effectiveness and cost efficiencies of the program.

A. Statutory Authority

1. **Waiver Authority.** The State's waiver program is authorized under section 1915(b) of the Act, which permits the Secretary to waive provisions of section 1902 for certain purposes. Specifically, the State is relying upon authority provided in the following subsection(s) of the section 1915(b) of the Act):

a. _X_ **1915(b)(1)** – The State requires enrollees to obtain medical care through a primary care case management (PCCM) system.

b. _X_ **1915(b)(2)** - A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among PCCMs.

Health Resources Coordinators (Medicaid staff) are responsible for the enrollment, disenrollment, and education of enrollees.

2. **Sections Waived.** Relying upon the authority of the above section(s), the State requests a waiver of the following sections of 1902 of the Act:

a. _X_ **Section 1902(a)(10)(B)** - Comparability of Services--This section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope.

This waiver program includes additional benefits such as case management and health education that will not be available to other Medicaid beneficiaries not enrolled in the waiver program.

b. _X_ **Section 1902(a)(23)** - Freedom of Choice--This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, beneficiaries enrolled in this program must receive certain services through a PCCM.

B. Delivery Systems

Delivery Systems. The State will be using the following systems to deliver services:

PCCM: A system under which a primary care case manager contracts with the State to furnish case management services. Reimbursement is on a fee-for-service basis.

C. Choice PCCMs

1. **Assurances.**

The State assures CMS that it complies with section 1932(a)(3) of the Act and 42 CFR 438.52, which require that a State that mandates Medicaid beneficiaries to enroll in a PCCM must give those beneficiaries a choice of at least two entities.

2. **Details**. The State will provide enrollees with the following choices:

Two or more PCCMs

D. Geographic Areas Served by the Waiver

1. **General**. Please indicate the area of the State where the waiver program will be implemented.

Statewide -- all counties, zip codes, or regions of the State

HC is implemented in all regions of the state. Management of the HC program is by region. One county in Region 7 does not have any health care providers. All participants must travel to neighboring regions for services and have the option to obtain services from the closest provider to their residence whether the PCP participates in HC or not.

E. Populations Included in Waiver

1. **Included Populations**. The following populations are included in the Waiver Program:

_X_ **Section 1931 Children and Related Populations** are children including those eligible under Section 1931, poverty-level related groups and optional groups of older children.

_X_ Mandatory enrollment (in mandatory counties)
_X_ Voluntary enrollment (in voluntary counties)

_X_ **Section 1931 Adults and Related Populations** are adults including those eligible under Section 1931, poverty-level pregnant women and optional group of caretaker relatives.

_X_ Mandatory enrollment (in mandatory counties)
_X_ Voluntary enrollment (in voluntary counties)

_X_ **Blind/Disabled Adults and Related Populations** are beneficiaries, age 18 or older, who are eligible for Medicaid due to blindness or disability. Report Blind/Disabled Adults who are age 65 or older in this category, not in Aged.

_X_ Mandatory enrollment (in mandatory counties)
_X_ Voluntary enrollment (in voluntary counties)

_X_ **Blind/Disabled Children and Related Populations** are beneficiaries, generally under age 18, who are eligible for Medicaid due to blindness or disability.

_X_ Mandatory enrollment (in mandatory counties)
_X Voluntary enrollment (in voluntary counties)

_X_ **Aged and Related Populations** are those Medicaid beneficiaries who are age 65 or older and not members of the Blind/Disabled population or members of the Section 1931 Adult population.

_X_ Mandatory enrollment (in mandatory counties)
_X_ Voluntary enrollment (in voluntary counties)

_X_ **Foster Care Children** are Medicaid beneficiaries who are receiving foster care or adoption assistance (Title IV-E), are in foster-care, or are otherwise in an out-of-home placement.

_X_ Mandatory enrollment (in mandatory counties)

_X_ Voluntary enrollment (in voluntary counties)

_X TITLE XXI SCHIP is an optional group of targeted low-income children who are eligible to participate in Medicaid if the State decides to administer the State Children's Health Insurance Program (SCHIP) through the Medicaid program.

_X_ Mandatory enrollment (in mandatory counties)
_X_ Voluntary enrollment (in mandatory counties)

2. **Excluded Populations.** Please indicate populations which are excluded from participating in the Waiver Program:

_X_ Reside in Nursing Facility or ICF/MR--Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Mentally Retarded (ICF/MR).

_X_ Eligibility Less Than 3 Months--Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program.

_X_ **Retroactive Eligibility** – Medicaid beneficiaries for the period of retroactive eligibility.

F. Services

List all services to be offered under the Waiver in Appendices D2.S. and D2.A of Section D, Cost-Effectiveness.

1. **Assurances.**

_X_ The State assures CMS that services under the Waiver Program will comply with the following federal requirements:

- Services will be available in the same amount, duration, and scope as they are under the State Plan per 42 CFR 438.210(a)(2).
- Access to emergency services will be assured per section 1932(b)(2) of the Act and 42 CFR 438.114.
- Access to family planning services will be assured per section 1905(a)(4) of the Act and 42 CFR 431.51(b)
- Referrals to 1915 (c) program (HCBS) will be made when medical necessity is met.

_X_ The CMS Regional Office has reviewed and approved the PCCM contracts for compliance with the provisions of 42 CFR 438.210(a)(2), 438.114, and 431.51 (Coverage of Services, Emergency Services, and Family Planning) as applicable, and these contracts are effective for the period ____ to ____.

Contract is effective date signed by provider and the Department until revoked by either party.

2. **Family Planning Services.** In accordance with sections 1905(a)(4) and 1915(b) of the Act, and 42 CFR 431.51(b), prior authorization of, or requiring the use of network providers for family planning services is prohibited under the waiver program. Out-of-network family planning services are reimbursed in the following manner:

Family planning services do not require a referral from the PCP.

3. **FQHC Services**. In accordance with section 2088.6 of the State Medicaid Manual, access to Federally Qualified Health Center (FQHC) services will be assured in the following manner:

_X_ The program is **voluntary** in some counties, and the enrollee can disenroll at any time if he or she desires access to FQHC services. The PCCM is not required to provide FQHC services to the enrollee during the enrollment period.

All FQHCs are HC providers and the participant may choose them as their PCP

_X_ The program is **mandatory** in some counties and the enrollee is guaranteed a choice of at least one PCCM which has at least one FQHC as a participating provider. If the enrollee elects not to select a PCCM that gives him or her access to FQHC services, no FQHC services will be required to be furnished to the enrollee while the enrollee is enrolled with the PCCM he or she selected. Since reasonable access to FQHC services will be available under the waiver program, FQHC services outside the program will not be available. Please explain how the State will guarantee all enrollees will have a choice of at least one PCCM with a participating FQHC:

All FQHCs are HC providers and the participant may choose them as their PCP.

4. **EPSDT Requirements.**

_X_ The managed care programs(s) will comply with the relevant requirements of sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements including informing, reporting, etc.), and 1905(r) (definition) of the Act related to Early, Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

5. **Self-referrals.**

_X_ The State requires PCCMs to allow enrollees to self-refer (i.e. access without prior authorization) under the following circumstances or to the following subset of services in the PCCM contract:

Services provided in an Emergency Department
Family Planning Services

Note: Women who wish to be treated by an OB/GYN during pregnancy and are unable to obtain a referral from their PCP may request an exemption from the HC program during the pregnancy and self refer to an OB/GYN for the term of the pregnancy.

Section A: Program Description

Part II: Access

Each State must ensure that all services covered under the State plan are available and accessible to enrollees of the 1915(b) Waiver Program. Section 1915(b) of the Act prohibits restrictions on beneficiaries' access to emergency services and family planning services.

A. Timely Access Standards

1. **Assurances PCCM programs.** The State must assure that Waiver Program enrollees have reasonable access to services. Please note below the strategies the State uses to assure timely access to services.

a. _X_ **Availability Standards.** The State's PCCM Program includes established maximum distance and/or travel time requirements, given beneficiary's normal means of transportation, for waiver enrollees' access to the following providers.

1._X_ PCPs (please describe):

30 miles or 30 minutes each way

2.___

b. _X_ **Appointment Scheduling** means the time before an enrollee can acquire an appointment with his or her provider for both urgent and routine visits. The State's PCCM Program includes established standards for appointment scheduling for waiver enrollee's access to the following providers.

_X_ PCPs

Less than 48 hours for urgent care
Less than 14 days for routine care

B. Capacity Standards

Assurances for PCCM program. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below which of the strategies the State uses assure adequate provider capacity in the PCCM program.

_X_ The State ensures that there is an **adequate number** of PCCM PCPs under the waiver assure access to all services covered under the Waiver. Please describe the State's standard for adequate PCP capacity.

Prior to requiring mandatory enrollment in the HC program, signed agreements are obtained from participating providers in the county, adjoining county (if applicable) that they will on a rotational basis, take all Medicaid participants assigned to them. If one or more providers limits their assignment in any way the remaining providers have to agree to take an additional share.

C. Coordination and Continuity of Care Standards

1. **Assurances for PCCM program**. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below the strategies the State uses assure coordination and continuity of care for PCCM enrollees.

a. _X_ Each enrollee selects or is assigned to a **primary care provider** appropriate to the enrollee's needs.

b. _X_ Each enrollee selects or is assigned to a **designated health care practitioner** who is primarily responsible for coordinating the enrollee's overall health care.

c. _X_ Each enrollee is receives **health education/promotion** information. Please explain.

Upon enrollment in the program, each enrollee is sent a booklet that explains the Medicaid program services and HC specific information that they need to be able to access services appropriately.

In addition, Health promotion materials are available to providers to give to enrollees as needed and appropriate.

d. _X_ Each provider maintains, for Medicaid enrollees, **health records** that meet the requirements established by the State, taking into account professional standards.

e. _X_ There is appropriate and confidential **exchange of information** among providers.

f. _X_ **Additional case management** is provided (please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case manager's files).
State plan case management (service coordination) is available to the following target populations: EPSDT, individuals receiving PCS or A&D waiver services, individuals with severe and persistent mental illness, and individuals with developmental disabilities.
Service coordination services require a referral from the PCP. Service coordinators must send the PCP copies of evaluations and service plans. PCP makes referrals for needed services identified by the service coordinator if medically necessary.

g. _X_ **Referrals**: Please explain in detail the process for a patient referral. In the description, please include how the referred services and the medical

forms will be coordinated among the practitioners, and documented in the primary care case managers' files.

PCPs make referrals by:

- Filling out a referral form or Rx form and either sending it with the patient or sending it by mail, Fax, to the receiving provider
- Phoning the referral to the receiving provider – if the referral is by phone the details of the referral are required to be written in the patient's file by both the referring and receiving providers
- All referrals are to be documented in the permanent patient record of both providers. Providers receiving referrals are to report outcomes back to the PCP
- HC referrals for the 1915(c) DD and ISSH waivers are required in addition to evaluation for medical necessity and prior-authorization by the Department. The PCP referral for the Developmental Disability and Idaho State School and Hospital waivers are for the following purposes only: safety in self-administration of medications, necessity for skilled nursing services, and medical restrictions on developmental therapy services. A PCP cannot refuse to give a referral for non-medical DD/ISSH HCBS services if the individual meets Medicaid medical necessity criteria for those services,, but have input into the services needed per the purposes described above. A PCP referral is not required for the Aged and Disabled or Traumatic Brain Injury waivers. The Regional Medicaid Unit makes medical necessity determinations and prior authorizes all HCBS waiver services (A&D, TBI, DD, and ISSH) waivers and send copies of evaluations and authorized plans to the PCP for continuity of care coordination.

Section A: Program Description

Part III: Quality

1. **Assurances for PCCM program**. The State must assure that Waiver Program enrollees have access to medically necessary services of adequate quality. Please note below the strategies the State uses to assure quality of care in the PCCM program.

a. _X_ The State has developed a set of overall quality **improvement guidelines** for its PCCM program. Please attach.

b. _X_ **State Intervention**: If a problem is identified regarding the quality of services received, the State will intervene as indicated below. Please check which methods the State will use to address any suspected or identified problems.

1._X_ Provide education and informal mailings to beneficiaries and PCCMs;

2._X_ Initiate telephone and/or mail inquiries and follow-up;

3._X_ Request PCCM's response to identified problems;

4._X_ Refer to program staff for further investigation;

5._X_ Send warning letters to PCCMs;

6.___ Refer to State's medical staff for investigation;

7._X_ Institute corrective action plans and follow-up;

8._X_ Change an enrollee's PCCM;

9.__ Institute a restriction on the types of enrollees;

10._X Further limit the number of assignments;

11.__ Ban new assignments;

12._X Transfer some or all assignments to different PCCMs;

13._X_ Suspend or terminate PCCM agreement;

14._X_ Suspend or terminate as Medicaid providers; and

15.___ Other (explain):

c. ___ **Selection and Retention of Providers**: This section provides the State the opportunity to describe any requirements, policies or procedures it has in place to allow for the review and documentation of qualifications and other relevant information pertaining to a provider who seeks a contract with the State or PCCM administrator as a PCCM. Please check any processes or procedures listed below that the State uses in the process of selecting and retaining PCCMs. The State (please check all that apply):

1. _X_ Has an initial credentialing process for PCCMs that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.

2. _X_ Notifies licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of PCCMs take place because of quality deficiencies.

Section A: Program Description

Part IV: Program Operations

A. Marketing

Marketing includes indirect PCCM administrator marketing (e.g., radio and TV advertising for the PCCM in general) and direct PCCM marketing (e.g., direct mail to Medicaid beneficiaries).

1. **Assurances**

__X_ The State assures CMS that it complies with section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities; in so far as these regulations are applicable.

_X_ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities and these contracts are effective for the period ___ to ___.

Our PCCM contracts are effective the date the provider enrolls as a HC provider and does not have an end date.

2. **Details**

a. **Scope of Marketing**

_X_ The State permits direct MCO/PIHP/PAHP or PCCM marketing (e.g., direct mail to Medicaid beneficiaries). Please list types of direct marketing permitted.

PCPs are prohibited from marketing to Medicaid participants, with the exception of contacting established patients (as identified by the Department) to request enrollment using materials developed by the Department.

b. **Description**. Please describe the State's procedures regarding direct and indirect marketing by answering the following questions, if applicable.

1.__X The State prohibits or limits PCCM's from offering gifts or other incentives to potential enrollees. Please explain any limitation or prohibition and how the State monitors this.

The state monitors this through a question on the enrollee survey. See page 18 of Client Survey. "Has anyone ever offered you anything as a free gift or favor if you enrolled in Healthy Connections?"

B. Information to Potential Enrollees and Enrollees

1. **Assurances.**

_X_ The State assures CMS that it complies with Federal Regulations found at section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements; in so far as these regulations are applicable.

_X_ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements and these contracts are effective for the period ___ to ___.

Our PCCM contracts are effective the date the provider enrolls as a HC provider and does not have an end date.

2. **Details.**

a. **Non-English Languages**

_X_ Potential enrollee and enrollee materials will be translated into the **prevalent non-English languages** listed below

The State defines prevalent non-English languages spoken by approximately _5__ percent or more of the potential enrollee/ enrollee population.

_X_ Please describe how **oral translation** services are available to all potential enrollees and enrollees, regardless of language spoken.

The Medicaid program will reimburse providers for interpreter services regardless of the language spoken.

_X_ The State will have a **mechanism** in place to help enrollees and potential enrollees understand the managed care program. Please describe.

Program information is sent with enrollment information to assist participants to understand the program. We are also developing a new combined Medicaid Information/HC Information Booklet this waiver period that was developed with input from focus groups of Medicaid participants. This booklet will be sent to all enrollees and all new enrollees.

All written information gives phone numbers for enrollees to call if they have any questions or problems regarding the program.

b. **Potential Enrollee Information**

Information is distributed to potential enrollees by:

The State

c. Enrollee Information

The State has designated the following as responsible for providing required information to enrollees:

The State

C. Enrollment and Disenrollment

1. **Assurances.**

_X_ The State assures CMS that it complies with section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment; in so far as these regulations are applicable.

_X_ The CMS Regional Office has reviewed and approved the PCCM contracts for compliance with the provisions of section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment requirements and these contracts are effective for the period ___ to ___.

Our PCCM contracts are effective the date the provider enrolls as a HC provider and does not have an end date.

2. **Details**. Please describe the State's enrollment process for PCCMs by checking the applicable items below.

a. _X_ **Outreach.** The State conducts outreach to inform potential enrollees, providers, and other interested parties of the managed care program. Please describe the outreach process, and specify any special efforts made to reach and provide information to special populations included in the waiver program:

When a county is in the process of becoming mandatory (we only have 9 of the 44 left to implement as mandatory), participants are sent an letter explaining the program and the need for them to fill out the attached enrollment form. It explains that if the do not enroll they will be auto-enrolled. The letter also informs them of public meeting date(s) where they will be able to come to hear a presentation and ask questions.

In addition to the above letters are sent to other impacted providers explaining impact of mandatory county status on them. Meetings are also held for these groups if requested.

b. **Administration of Enrollment Process**.

_X_ State staff conducts the enrollment process.

c. **Enrollment.** The State has indicated which populations are mandatorily enrolled and which may enroll on a voluntary basis in Section A.I.E.

_X_ If a potential enrollee **does not select** a PCCM within the given time frame, the potential enrollee will be **auto-assigned** or default assigned to a plan.

Mandatory counties only

i. X__ Potential enrollees will have_60_days/month(s) to choose a plan.
ii. X__ Please describe the auto-assignment process and/or algorithm.

The auto assignment process is conducted manually by state staff and follows the algorithm agreed to by the participating providers in the "Memorandum of Participation" In counties with either Pediatricians, Internists, and/or OB/GYNs, the rotational assignment is further refined to place enrollees with the appropriate type of PCP.

_X_ The State allows otherwise mandated beneficiaries to request **exemption** from enrollment in an PCCM. Please describe the circumstances under which a beneficiary would be eligible for exemption from enrollment. In addition, please describe the exemption process:

Potential or existing mandated participants may request an exemption from enrollment if one or more of the following circumstances exist:

A. The participant must travel more than 30 minutes or 30 miles to the nearest HC provider when a non-HC PCP is closer
B. The participant has an existing primary care relationship with a PCP provider/clinic not participating in HC
C. The participant has been placed on FFS utilization management lock-in
D. The participant has an incompatible third party liability
E. The participant wishes to obtain OB services from an OB specialist during pregnancy and HC OB is not available.

The enrollment letter describes the exemptions, how and where to apply. The request is reviewed against the criteria above and either an approval or a

denial letter is sent to the participant. All granted exemptions are entered into a database and are reviewed on an annual basis to determine if any of the exemption criteria are still met.

_X__ The State **automatically re-enrolls** a beneficiary with the same PCCM or if there is a loss of Medicaid eligibility of 2 months or less.

We currently do not disenroll enrollees from HC for loss of Medicaid eligibility until 2 months have lapsed. This prevents Medicaid eligibles that gain and loose Medicaid eligibility for short periods of time from having to re-enroll every time they loose eligibility for less than 2 months. We do however discontinue the payment of the CM fee for the PCP during the Medicaid ineligible period to assure that FFP is not claimed during the Medicaid ineligible period.

d. **Disenrollment:**

_X_ The State **does not have a lock-in into the HC program**, and enrollees in MCOs/PIHPs/PAHPs and PCCMs are allowed to terminate or change their enrollment without cause at any time. The disenrollment/transfer is effective no later than the first day of the second month following the request.

Requests made after the 20th of the month are not effective until the 2nd month after the request.

_X_ The State permits **PCCMs to request disenrollment** of enrollees.

i._X_ PCCM can request reassignment of an enrollee for the following reasons:

- The client fails to follow treatment plan
- The client misses appointments without notifying provider
- The client/PCP relationship is not mutually acceptable
- The clients condition would be better treated by another provider
- The PCP has moved and/or is no longer in practice

Enrollees disenrolled by a PCCM in a mandatory county are given the opportunity to chose another PCP or accept assignment per the rotation agreement. Enrollees living in voluntary counties may choose to enroll with another participating HC provider or disenroll and receive services from any participating Medicaid provider. All services in Idaho's Medicaid program are FFS whether the participant is enrolled in HC or not.

ii._X_ The State reviews and approves all PCCM-initiated requests for enrollee transfers or disenrollments.

D. Enrollee rights.

1. **Assurances.**

_X_ The State assures CMS that it complies with section 1932(a)(5)(B)(ii) of the Act and 42 CFR 438 Subpart C Enrollee Rights and Protections.

_X_ The CMS Regional Office has reviewed and approved the PCCM contracts for compliance with the provisions of section 1932(a)(5)(B)(ii) of the Act and 42 CFR Subpart C Enrollee Rights and Protections, and these contracts are effective for the period ___ to ___.

Our PCCM contracts are effective the date the provider enrolls as a HC provider and does not have an end date. All providers have signed the new contract that CMS approved effective 10/1/2002.

_X_ The State assures CMS it will satisfy all HIPAA Privacy standards as contained in the HIPAA rules found at 45 CFR Parts 160 and 164.

E. Grievance System

1. **Assurances for All Programs**. States PCCM programs are required to provide Medicaid enrollees with access to the State fair hearing process as required under 42 CFR 431 Subpart E, including:

a. informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action,

b. ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if State takes action without the advance notice and as required in accordance with State Policy consistent with fair hearings. The State must also inform enrollees of the procedures by which benefits can be continued for reinstated, and

c. other requirements for fair hearings found in 42 CFR 431, Subpart E.

_X_ The State assures CMS that it complies with Federal Regulations found at 42 CFR 431 Subpart E.

2. **Optional grievance systems for PCCM programs**. States, at their option, may operate a PCCM grievance procedure (distinct from the fair hearing process) administered by the State agency or the PCCM that provides for prompt resolution of issues. These grievance procedures are strictly voluntary and may not interfere with a PCCM, enrollee's freedom to make a request for a fair hearing or a PCCM enrollee's direct access to a fair hearing in instances involving terminations, reductions, and suspensions of already authorized Medicaid covered services.

_X_ The State has a grievance procedure for its _X_ PCCM program characterized by the following:

:

_X_ The grievance procedures is operated by:

The State

___ Please provide definitions the State employs for the PCCM grievance system (e.g. grievance, appeals)

- Concern/Problem/Complaint: Issues that are because of dissatisfaction with an action, service, rule, law in the Idaho Medicaid Healthy Connections program
- Appeal: Dissatisfaction with a Department decision when the Department is not able to change the decision based on application of law or rules. An appeal is heard by an Administrative Hearing Officer
- Grievance: Process by which a provider or enrollee may request a change in the decision or action of a provider or

the Dept. and it cannot be resolved at the local level. This step generally happens before an appeal.

- Problem resolution: the process of resolving complaints or concerns for enrollee, PCPs or other providers – Involves liaison between the affected parties

_X_ Has a grievance committee or staff who review and resolve grievances.

All grievances are reviewed and resolved by the State Waiver Quality Assurance Manager

_X_ Reviews requests for reconsideration of initial decisions not to provide or pay for a service.

_X Has time frames for staff to resolve grievances for PCCM grievances. Specify the time period set: _30 calendar days_____

_X_ Notifies the enrollee in writing of the grievance decision and further opportunities for appeal, as well as the procedures available to challenge or appeal the decision.

F. Program Integrity

1. **Assurances.**

_X_ The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.610 Prohibited Affiliations with Individuals Barred by Federal Agencies. The State assures that it prohibits a PCCM from knowingly having a relationship listed below with:

(1) An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or

(2) An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above.

The prohibited relationships are:

(1) A director, officer, or partner of the PCCM;

(2) A person with beneficial ownership of five percent or more of the PCCM's equity;

(3) A person with an employment, consulting or other arrangement with the PCCM for the provision of items and services that are significant and material to the PCCM's obligations under its contract with the State.

_X_ The State assures that it complies with section 1902(p)(2) and 42 CFR 431.55, which require section 1915(b) waiver programs to exclude entities that:

1) Could be excluded under section 1128(b)(8) of the Act as being controlled by a sanctioned individual;
2) Has a substantial contractual relationship (direct or indirect) with an individual convicted of certain crimes described in section 1128(b)(8)(B) of the Act;
3) Employs or contracts directly or indirectly with an individual or entity that is
    a. precluded from furnishing health care, utilization review, medical social services, or administrative services pursuant to section 1128 or 1128A of the Act, or
    b. could be exclude under 1128(b)(8) as being controlled by a sanctioned individual.

Section B: Monitoring Plan

Per section 1915(b) of the Act and 42 CFR 431.55, states must assure that 1915(b) waiver programs do not substantially impair access to services of adequate quality where medically necessary. To assure this, states must actively monitor the major components of their waiver program described in Part I of the waiver preprint:

Program Impact	(Choice, Marketing, Enrollment/Disenrollment, Program Integrity, Information to Beneficiaries, Grievance Systems)
Access	(Timely Access, PCP Capacity, Specialty Capacity, Coordination and Continuity of Care)
Quality	(Coverage and Authorization, Provider Selection, Quality Assessment and Performance Improvement, PCCM Quality)

For each of the programs authorized under this waiver, this Part identifies how the state will monitor the major areas within Program Impact, Access, and Quality. It acknowledges that a given monitoring strategy may yield information about more than one component of the program. For instance, consumer surveys may provide data about timely access to services as well as measure ease of understanding of required enrollee information.

PCCM programs. The Medicaid Managed Care regulations in 42 CFR Part 438 establishes certain beneficiary protections for PCCM programs that correspond to the waiver areas under "Program Impact." However, generally the regulations do not stipulate access or quality standards for PCCM programs. State must assure access and quality in PCCM waiver programs, but have the flexibility to determine how to do so and which monitoring strategies to use.

I. Summary chart

States should use the chart on the next page to summarize the strategies used to monitor major areas of the waiver program. If this waiver authorizes multiple programs, the state may use a single chart for all programs or replicate the chart and fill out a separate one for each program. If using one chart for multiple programs, the state should enter the program acronyms (MCO, PIHP, etc.) in the relevant box.

Strategy	Program Impact						Access			Quality		
	Choice	Marketing	Enroll Disenroll	Program .Integrity	Information	Grievance	Timely Access	PCP/Specialist Capacity	Coordination Continuity	Coverage Authorization	Provider Selection	Quality of Care
Accreditation for Deeming												
Accreditation for Participation												
Consumer Self-Report data		X			X		X	X				X
Data Analysis (non-claims)							X					X
Enrollee Hotlines			X			X	X	X				X
Focused Studies												
Geographic mapping												
Independent Assessment												
Measure any Disparities by Racial or Ethnic Groups												
Network Adequacy Assurance by												

Strategy	Program Impact						Access			Quality		
	Choice	Marketing	Enroll Disenroll	Program .Integrity	Information	Grievance	Timely Access	PCP/Specialist Capacity	Coordination Continuity	Coverage Authorization	Provider Selection	Quality of Care
Plan												
Ombudsman												
On-Site Review												
Performance Improvement Projects												
Performance Measures												
Periodic Comparison of # of Providers												
Profile Utilization by Provider Caseload												
Provider Self-Report Data					X		X	X	X			
Test 24/7 PCP Availability							X					
Utilization Review												
Other: (describe)												

Strategy	Program Impact						Access			Quality		
	Choice	Marketing	Enroll Disenroll	Program .Integrity	Information	Grievance	Timely Access	PCP/Specialist Capacity	Coordination Continuity	Coverage Authorization	Provider Selection	Quality of Care
Mandatory County Contracts (Memorandums of Participation)								X				

II. Monitoring Strategies

Please check each of the monitoring strategies or functions below used by the state. A number of common strategies are listed below, but the state should identify any others it uses. If federal regulations require a given strategy, this is indicated just after the name of the strategy. If the state does not use a required strategy, it must explain why.

For each strategy, the state must provide the following information:

- Applicable programs (if this waiver authorizes more than one type of managed care program)
- Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor)
- Detailed description of strategy
- Frequency of use
- How it yields information about the area(s) being monitored

a. _X__ Consumer Self-Report data

_X_ State-developed survey

A statewide enrollee satisfaction survey is conducted at least bi-annually by the Waiver Quality Assurance Manager. The survey is sent to a random sample of enrollees from mandatory counties and a random sample of enrollees from voluntary counties. Information is collated and analyzed by our Data Unit. A report and any needed recommendations for program QA or QI are presented to the Quality Oversight Committee. The survey has standard questions around participation, understanding of program materials, help when needed from local representatives, types of questions they have had, access questions (waiting times, travel distances, etc.), quality of care, access to specialists, well child checks and immunizations, marketing, and any additional information we want to receive (such as ER utilization).

b. _X__ Data Analysis (non-claims)

___ Denials of referral requests
_X_ Disenrollment requests by enrollee
_X_ Grievances and appeals data

Enrollees are required to call the local Health Resources Coordinators in the Regions to request a change in providers and in voluntary counties to disenroll. An interview is conducted and reason codes are entered into the MMIS. Annually a report is pulled on the disenrollment reason codes and an analysis is completed by the statewide Waiver Quality Assurance

Manager. Any trends, problem areas, etc. are reported to the Quality Oversight Committee with recommendations for action if needed.

Beginning in July of 2004, all Department complaints (including those regarding the HC program will be tracked in a database that will allow tracking, trending and analysis of HC informal problem resolution and complaints. The database will have reporting capability and reports will be analyzed on a semi-annual basis by the Statewide Waiver Quality Assurance Manager. Issues will be reported semi-annually to the Quality Oversight Committee for decisions on any needed program changes, improvements, actions needed.

c. _X__ Enrollee Hotlines operated by State

Telephone numbers and addresses of the 14 Regional Health Resources Coordinator are published on all written HC materials and enrollees are encouraged to call whenever they have questions, concerns, or complaints.

d. _X__ Provider Self-report data
_X_ Survey of providers

All HC providers are surveyed bi-annually by the statewide Quality Assurance Manager. Questions focus on patient/physician relationships, utilization control, health education efforts, relationships with the local Health Resources Coordinators, availability of specialists, etc. The report is generated by the Data Unit and analysis and report to the Quality Oversight Committee is by the statewide Waiver Quality Assurance Manager.

e. __X__ Test 24 hours/7 days a week PCP availability

The Regional Health Resources Coordinator conduct monitoring calls to all HC PCP's to verify compliance with the 24-hour access coverage twice a year. In addition, "random calls" as well as follow-up calls will be made to PCPs if an access problem is reported to the HRC by another provider/facility or a HC client. All new PCPs will be called the first week of HC participation to verify compliance.

Regional reports are sent to the statewide Quality Assurance Manager for compiling, looking at any statewide issues, trends, problems. Analysis along with any recommendations for improvement are reported to the Quality Oversight Committee semi-annually.

f. __X__ Other: (please describe)

Idaho monitors PCP access and capacity through on-going memorandums of participation that are required prior to making a specific county mandatory. All participating providers in the county must agree to a rotational assignment of Medicaid and agree that they will assure a PCP assignment for all HC eligible Medicaid eligibles.

Section C: Monitoring Results

Section 1915(b) of the Act and 42 CFR 431.55 require that the State must document and maintain data regarding the effect of the waiver on the accessibility and quality of services as well as the anticipated impact of the project on the State's Medicaid program. In Section B of this waiver preprint, the State describes how it will assure these requirements are met. For an initial waiver request, the State provides assurance in this Section C that it will report on the results of its monitoring plan when it submits its waiver renewal request. For a renewal request, the State provides evidence that waiver requirements were met for the most recent waiver period. Please use Section D to provide evidence of cost-effectiveness.

CMS uses a multi-pronged effort to monitor waiver programs, including rate and contract review, site visits, reviews of External Quality Review reports on MCOs/PIHPs, and reviews of Independent Assessments. CMS will use the results of these activities and reports along with this Section to evaluate whether the Program Impact, Access, and Quality requirements of the waiver were met.

_X_ This is a renewal request. The State provides below the results of monitoring strategies conducted during the previous waiver.

Please replicate the template below for each strategy identified in Section B:

Strategy: Consumer Self-Report Data
Confirmation it was conducted as described:
_X_ Yes

Summary of results: See results of 2003 Healthy Connections Client Survey attached and Disenrollment/Change QA Report
Problems identified: Most of the issues identified in the 2003 Client survey were directly related to enrollees reading the information sent to them and understanding program requirements.
No significant issues with waiting times, referrals, or quality of care were identified on change disenrollment report.
Corrective action (plan/provider level): N/A
Program change (system-wide level): Two actions were taken in 2003-2004 to address the problems identified in this survey: 1) client focus groups were held in three regions of the state to identify the best way to get information to our clients, format to increase chances of their reading it, understandability of the information, etc. 2) Client informational materials are being revised to incorporate what we learned in the focus groups.

Strategy: Data Analysis (non-claims)
Confirmation it was conducted as described:
_X_ Yes
Summary of results:

Study of data for 2002/2003 disenrollment reason codes for waiting times, and denial of referrals did not show any significant trends or problems. The rates for disenrollments for perceived quality of care issues were slightly higher than the other monitors, but were still not very high. For 2002, the average statewide was 4% of the disenrollments were for perceived quality of care issues. For 2003, the average dropped to 3%.
Problems identified:

Corrective action (plan/provider level): None
Program change (system-wide level): None

Strategy: Enrollee Hot Line
Confirmation it was conducted as described:
_X_ Yes
Summary of results:
We are implementing a statewide, automated database for tracking customer concern/complaints regarding services provided by the Dept. of H&W in July of 2004. This database will allow us to track, trend, assure quality and make program improvements in the Healthy Connections program.
Problems identified:

Corrective action (plan/provider level): N/A
Program change (system-wide level): N/A

Strategy: Provider Self Report Data
Confirmation it was conducted as described:
_X_ Yes
Summary of results: See attached Provider 2003 Survey
Problems identified: The survey supported our data from the enrollee (client) survey that the biggest issue is the understanding of the program by the enrollees.
The survey also supported our premise that HC providers are the best conduit to get health information to our enrollees.

Corrective action (plan/provider level): Continue current project to improve the understandability of our program materials and look at better ways to ensure that enrollees read the information.
The program is developing health educations materials for HC providers to provide to enrollees as appropriate. We will be using the same information we obtained from focus groups to provide the information in understandable formats.
Program change (system-wide level): New materials

Strategy: Test 24/7 PCP Availability
Confirmation it was conducted as described:
_X_ Yes

Summary of results: See copy of 2002/2003 Statewide 24 Hour Monitoring Report
Problems identified:
Information has not been trended and analyzed in the past.

Corrective action (plan/provider level):
Make changes in collection process to collect and trend non-compliance. Report to results to QI Oversight Committee bi-annually.